



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

RETURN TO:
PHARMACY AND CLINICAL SERVICES
BY FAX ONLY: 573-659-0209

MISSOURI MEDICAID EMERGENCY OVERRIDE AUTHORIZATION FORM

PLEASE PRINT OR TYPE
ALL REQUIRED INFORMATION MUST BE SUPPLIED OR THE REQUEST CANNOT BE PROCESSED

PLEASE CHECK ALL THAT APPLY:

- ☐ I HAVE PERFORMED AN E1 TRANSACTION
- ☐ I HAVE SUBMITTED THE CLAIM USING THE WELLPOINT OF SALE FACILITATED ENROLLMENT PROCESS
- ☐ I HAVE CALLED 1-800-MEDICARE AND RECEIVED NO ASSISTANCE
- ☐ I HAVE CALLED 1-866-835-7595 AND RECEIVED NO ASSISTANCE
- ☐ I HAVE CALLED THE PRESCRIPTION DRUG PLAN (PDP) AND RECEIVED NO ASSISTANCE

RECIPIENT NAME	DATE OF BIRTH	MEDICAID NUMBER
RECIPIENT ADDRESS	RECIPIENT PHONE NUMBER (INCLUDING AREA CODE)	
PART D PDP NAME	PDP ID NUMBER/HIC NUMBER	

IS THE PATIENT TOTALLY WITHOUT PRESCRIPTION COVERAGE AND/OR IN NEED OF SPECIFIC MEDICATION(S)?
☐ YES ☐ NO

IF THE PATIENT IS IN NEED OF SPECIFIC MEDICATION(S) **ONLY** PLEASE LIST DRUG NAME, STRENGTH AND FREQUENCY:

NAME OF PHARMACY AND CONTACT PERSON		MEDICAID PROVIDER (OR DEA) NUMBER
PHARMACY ADDRESS	PHARMACY TELEPHONE NUMBER	PHARMACY FAX NUMBER
NAME OF PHYSICIAN OR PERSON FILLING OUT FORM		MEDICAID PROVIDER (OR DEA) NUMBER
PHYSICIAN ADDRESS	PHYSICIAN TELEPHONE NUMBER	PHYSICIAN FAX NUMBER